13.d. Rehabilitative services. (continued)

(c) Have 18 hours of documented field supervision by a mental health professional or mental health practitioner during the first 160 hours of contact work with recipients and at least six hours of field supervision quarterly during the following year;

(d) Have review and cosignature of charting of recipient contacts during field supervision by a mental health professional or mental health practitioner; and

(e) Have 40 hours of additional continuing education on mental health topics during the first year of employment.

E. Receive ongoing continuing education training of at least 30 hours every two years in areas of mental illness and mental health services and other areas specific to the population being served.

Components of Mental Health Community Support Services

A mental health professional, a mental health practitioner under the clinical supervision of a mental health professional, and a mental health rehabilitation worker under the direction of a mental health professional or mental health practitioner and under the clinical supervision of a mental health professional must be capable of providing the following two components:

1. Basic living and social skills, which may include:

A. Communication skills.

B. Budgeting and shopping skills.

C. Healthy lifestyle skills.

D. Household management skills.

13.d. Rehabilitative services. (continued)

E. Transportation skills.

F. Medication monitoring.

G. Crisis assistance skills, including relapse prevention skills and developing a health care document.

2. Consultation with relatives, guardians, friends, employers, treatment providers, and other significant people, in order to change situations and allow the recipient to function more independently. The consultation must be directed exclusively to the treatment of the recipient.

A physician, pharmacist and registered nurse must be capable of providing medication education. Medication education includes training the recipient in the symptoms of mental illness, discussing the benefits and side effects of psychotropic medication, and discussing the importance of medication compliance. Medical education enables the recipient to better manage the symptoms of mental illness, allowing the recipient to return to independent functioning with less chance of relapse.

The services below are not eligible for medical assistance payment as mental health community support services:

1. Recipient transportation services.

2. Services billed by a nonenrolled Medicaid provider.

3. Services provided by volunteers.

4. Direct billing of time spent "on call" when not providing services.

5. Job-specific skills services, such as on-the-job training.

6. Performance of household tasks, chores, or related activities for the recipient.

7. Provider service time paid as part of case management services.

13.d. Rehabilitative services. (continued)

8. Outreach services, which means services identifying potentially eligible people in the community, informing potentially eligible people of the availability of medically needy mental health mental health community support services, and assisting potentially eligible people with applying for these services.

9. Services provided by a hospital, board and lodge facility, or residential facility to patients or residents. This includes services provided by an institution for mental disease.

- **Mental health crisis response services** are services recommended by a physician, mental health professional defined in item 6.d.A., or mental health practitioner defined on pages 53l-53m. An entity operated by or under contract with the county in the county in which the crisis occurs is eligible to provide mental health crisis response services.

  Mental health practitioners and mental health rehabilitation workers must complete at least 30 hours of training in crisis response services skills and knowledge every two years.

  The components of mental health crisis response services are:

  1. Crisis assessment. Crisis assessment is an immediate face-to-face appraisal by a physician, mental health professional, or mental health practitioner under the clinical supervision of a mental health professional, following a determination that suggests the recipient may be experiencing a mental health crisis.

     The crisis assessment is an evaluation of any immediate needs for which emergency services are necessary and, as time permits, the recipient's life situation, sources of stress, mental health problems and symptoms, strengths, cultural considerations, support network, vulnerabilities, and current functioning.

13.d. Rehabilitative services. (continued)

2. Crisis intervention. Crisis intervention is a face-to-face, short-term intensive service provided during a mental health crisis to help a recipient cope with immediate stressors, identify and utilize available resources and strengths, and begin to return to the recipient's baseline level of functioning. Crisis intervention must be available 24 hours a day, seven days a week.

A. Crisis intervention is provided after the crisis assessment.

B. Crisis intervention includes developing a crisis treatment plan. The plan must include recommendations for any needed crisis stabilization services. It must be developed no later than 24 hours after the first face-to-face intervention. The plan must address the needs and problems noted in the crisis assessment and include measurable short-term goals, cultural considerations, and frequency and type of services to be provided. The plan must be updated as needed to reflect current goals and services.

The crisis intervention team must document which short-term goals were met, and when no further crisis intervention services are required.

C. The crisis intervention team is comprised of at least two mental health professionals, or a combination of at least one mental health professional and one mental health practitioner with the required crisis training and under the clinical supervision of a mental health professional on the team. The team must have at least two members, with at least one member providing on-site crisis intervention services when needed.

D. If possible, at least two members must confer in person or by telephone about the assessment, crisis treatment plan, and necessary actions taken.

13.d. Rehabilitative services. (continued)

E. If a recipient's crisis is stabilized, but the recipient needs a referral to other services, the team must provide referrals to these services.

3. Crisis stabilization. Crisis stabilization is an individualized mental health service designed to restore a recipient to the recipient's prior functional level.

A. Crisis stabilization cannot be provided without first providing crisis intervention.

B. Crisis stabilization is provided by a mental health professional, a mental health practitioner who is under the clinical supervision of a mental health professional, or a mental health rehabilitation worker who meets the qualifications on pages 53a-53c, who works under the direction of a mental health professional or a mental health practitioner, and works under the clinical supervision of a mental health professional.

C. Crisis stabilization may be provided in the recipient's home, another community setting, or a short-term supervised, licensed residential program that is not an IMD. If provided in a short-term supervised, licensed residential program, the program must have 24-hour-a-day residential staffing, and the staff must have 24-hour-a-day immediate access to a qualified mental health professional or qualified mental health practitioner.

D. A crisis stabilization treatment plan must be developed, and services must be delivered according to the plan. A plan must be completed within 24 hours of beginning services and developed by a mental health professional or a mental health practitioner under the clinical supervision of a mental health professional. At a minimum, the plan

13.d. Rehabilitative services. (continued)

must contain:

(1) A list of problems identified in the assessment;

(2) A list of the recipient's strengths and resources;

(3) Concrete, measurable short-term goals and tasks to be achieved, including time frames for achievement;

(4) Specific objectives directed toward the achievement of each one of the goals;

(5) Documentation of the participants involved in the service planning. The recipient, if possible, must participate;

(6) Planned frequency and type of services initiated;

(7) The crisis response action plan if a crisis should occur; and

(8) Clear progress notes on the outcome of goals.

4. Consultation with relatives, guardians, friends, employers, treatment providers, and other significant people, in order to change situations and allow the recipient to function more independently. The consultation must be directed exclusively to the treatment of the recipient.

The services below are not eligible for medical assistance payment as mental health crisis response services:

1. Recipient transportation services.

2. Services provided by a nonenrolled Medicaid provider.

13.d. Rehabilitative services. (continued)

3. Room and board.

4. Services provided to a recipient admitted to an inpatient hospital.

5. Services provided by volunteers.

6. Direct billing of time spent "on call" when not providing services.

7. Provider service time paid as part of case management services.

8. Outreach services, defined on page 53e.

Rehabilitative services provided for **chemical abuse** are limited to:

(1) **Primary rehabilitation program:** A licensed chemical dependency rehabilitation program that provides intensive, primary therapeutic services to clients who do not require detoxification. Primary rehabilitation programs provide at least 30 hours a week per client of chemical dependency services including group and individual counseling, and other services specific to chemical dependency rehabilitation.

(2) **Outpatient rehabilitation program:** A program of at least 10 hours of therapy/counseling, including group, collateral, and individual therapy/counseling and may be provided to a recipient while the recipient resides in a supervised living facility, board and lodging facility, or the recipient's own home.

(3) **Extended rehabilitation program:** A licensed chemical dependency rehabilitation program that offers extended, long term in-house chemical dependency services. An extended rehabilitation program provides an average of 15 hours a week per client of chemical dependency services including group and individual counseling, client education, and other services specific to chemical dependency

13.d. Rehabilitative services. (continued)

rehabilitation.

(4) **Transitional rehabilitation program:** A licensed chemical dependency rehabilitation program that is offered in a transitional semi-independent living arrangement with an emphasis on aftercare and securing employment. A transitional rehabilitation program provides at least five hours a week per client of rehabilitation services which may include group counseling, employment counseling, and individual counseling.

Collateral counseling involves counseling provided directly or indirectly to the recipient through the involvement of the recipient's or significant others in the counseling process. Presence of the recipient in the counseling sessions is not necessarily required. However, when the recipient is present, reimbursement for collateral counseling and individual or group counseling for the same session is not allowed.

Rehabilitative services must be restorative or specialized maintenance therapy services and include medical treatment and physical or psychological therapy. These services are limited to services provided under the recommendation of a physician and must be a part of the recipient's plan of care.

Provider eligibility is limited to programs licensed by the Department of Human Services under Minnesota Rules, parts 9530.4100 through 9530.4450(Rule 35) and Minnesota Rules, parts 9530.5000 through 9530.6400 (Rule 43) or the American Indian programs, that if located outside of the federally recognized tribal lands would be required to be licensed.

Rehabilitative restorative and specialized maintenance physical therapy, occupational therapy, and speech, language and hearing therapy services.

Coverage is limited to services within the limitations provided under Items 11.a. to 11.c., Physical therapy services, Occupational therapy services, and Speech, language and hearing therapy services (provided by or under the supervision of a speech pathologist or audiologist), except:

13.d. Rehabilitative services. (continued)

(1) Services that are provided by a rehabilitation agency that take place in a sheltered workshop in a day training and habilitation center or a residential or group home that is an affiliate of the rehabilitation agency are not covered.

(2) Social and vocational adjustment services are not covered, but must be provided as an unreimbursed adjunct to the covered services.

Covered **respiratory therapy services** are those prescribed by a physician and provided by a qualified respiratory therapist.

EPSDT rehabilitative services identified in an Individualized Education Plan and provided to children with IEPs during the school day.

Covered services include speech, language and hearing therapy services, mental health services, physical and occupational therapy, assistive technology devices, and nursing services that are essential and adjunctive to the above services, such as catheterization, suctioning, tube feedings, medication administration and ventilator care. The services must meet all the requirements otherwise applicable if the service had been provided by a qualified, enrolled provider other than a school district, in the following areas: medical necessity, documentation, personnel qualifications, and invoicing and prior authorization requirements.

Appropriate nursing services must be provided pursuant to a physician's order. All other services must be provided pursuant to an order of a licensed practitioner of the healing arts.

School districts must secure informed consent to bill for each type of rehabilitative service. For the purposes of this item, "informed consent" means a written agreement, or an agreement as documented in the record, by a recipient or responsible party in accordance with Minnesota Statutes, section 13.05, subdivision 4, paragraph (d) and Minnesota Statutes, section 256B.77, subdivision 2, paragraph (p).

13.d. Rehabilitative services. (continued)

Covered services must be furnished by the following personnel:

(1) Audiologists meeting the requirements in 42 CFR Part 440.110.

(2) Occupational therapists meeting the requirements in 42 CFR Part 440.110.

(3) Physical therapists meeting the requirements in 42 CFR Part 440.110.

(4) Speech-language pathologists:

(a) meeting the requirements in 42 CFR Part 440.110;

(b) who hold a masters degree in speech-language pathology; and

(c) who are licensed by the state as educational speech-language pathologists.

5) Mental health professionals ~~who have a current Minnesota license as a licensed psychologist, psychiatrist, licensed independent clinical social worker, registered nurse with a master's degree and certificate from the American Nurses Association as a clinical specialist in psychiatric nursing or mental health, licensed psychological practitioner, or a licensed marriage or family therapist with at least two years of post-master's supervised experience~~ as defined in item 6.d.A.

(6) Mental health practitioners practicing under the supervision of mental health professionals who:

(a) hold a bachelor's degree in one of the behavioral sciences or related fields from an accredited college or university and:

(i) have at least 2,000 hours of supervised experience in the delivery of mental health services to children; or

13.d. Rehabilitative services. (continued)

(ii) are fluent in the non-English language of the ethnic group to which at least 50 percent of the practitioner's clients belong, complete 40 hours of training in the delivery of services to children, and receive clinical supervision from a mental health professional at least once a week until the requirement of 2,000 hours of supervised experience is met;

(b) have at least 6,000 hours of supervised experience in the delivery of mental health services to children;

(c) are graduate students in one of the behavioral sciences or related fields and are formally assigned by an accredited college or university to an agency or facility for clinical training; or

(d) hold a master's or other graduate degree in one of the behavioral sciences or related fields from an accredited college or university and have less than 4,000 hours post-master's experience in the treatment of emotional disturbance.

Mental health practitioners cannot provide psychological testing or diagnostic assessments.

(7) Physicians who have a current Minnesota license as a physician.

(8) Registered nurses and licensed practical nurses who have a current Minnesota license as registered nurses or practical nurses.

4.b. Early and periodic screening, diagnosis, and treatment services:

EPSDT services are paid the lower of the submitted charge or the 75th percentile of all screening charges submitted by providers of the service during the previous 12-month period of July 1 to June 30. The adjustment necessary to reflect the 75th percentile is effective annually on October 1.

Effective for mental health rehabilitative services provided on or after July 1, 2001, payment is the lower of the submitted charge or 75.6% of the 50th percentile of 1999 charges.

- Effective January 1, 2002, provider travel time is covered if a recipient's individual treatment plan requires the provision of psychotherapy services outside of the provider's normal place of business.

- **Crisis intervention and crisis stabilization services** provided as part of family community support services are paid:

  - for doctoral prepared mental health professionals, the lower of the submitted charge or ~~$39.00~~ $43.50 per 30 minute unit;

  - for master's prepared mental health professionals, the lower of the submitted charge or ~~$31.20~~ $34.80 per 30 minute unit;

  - for mental health practitioners supervised by doctoral prepared mental health professionals, the lower of the submitted charge or ~~$19.50~~ $21.75 per 30 minute unit; or

  - for mental health practitioners supervised by master's prepared mental health professionals, the lower of the submitted charge of ~~$15.60~~ $17.40 per 30 minute unit.

4.b. Early and periodic screening, diagnosis, and treatment services: (continued)

- **Mental health behavioral aide services** provided as part of family community support services are paid:
  - for Level I MHBAs, the lower of the submitted charge or $9.40 per 30 minute unit;
  - for Level II MHBAs, the lower of the submitted charge of $12.28 per 30 minute unit; or
  - for mental health professional or mental health practitioner direction of MHBAs, the lower of the submitted charge or $13.70 per 30 minute unit.
- **Therapeutic components of preschool programs** provided as family community support services are paid the lower of the submitted charge or $27.50 per one hour unit.
- **Therapeutic components of therapeutic camp programs** provided as family community support services are paid the lower of the submitted charge or $19.32 per one hour unit.
- **Services provided to recipients with severe emotional disturbance residing in a children's residential treatment facility** is based on the daily rate negotiated by the county. The county will pay the residential facility the full negotiated rate and certify to the Department that the rate paid represents expenditures eligible for the matching Federal medical assistance percentage. The county is responsible for the nonfederal share.

  The Department, using the rate methodology below, determines the medical assistance percentage of the per day negotiated rate and submits a claim to HCFA. The Department returns to the county the Federal medical assistance percentage.

  Rate Methodology

  The negotiated daily rate paid to a children's residential treatment facility is the same for medical assistance-eligible and non medical assistance-eligible individuals.

4.b. Early and periodic screening, diagnosis, and treatment services: (continued)

Beginning July 1, 2000, the allowable medical assistance daily rate is determined using a statistically valid random day log time study containing various activity categories and an annual facility cost report.

The time study of facility staff determines the percent of time spent by direct service staff on various specific activity categories constituting allowable and unallowable rehabilitative activities.

The annual cost report from each facility provides a breakdown of facility costs into the same activity categories utilized in the time study and a breakdown of allowable and unallowable medical assistance costs. The results of the time study determine the amount of salary and fringe benefit costs for direct service staff that are charged to each activity category. Direct costs are those costs attributable to a specific activity and, therefore, are charged directly to that time study activity category. Salary, fringe and direct costs are totaled for each category and then indirect costs are allocated to each category based on the proportion of each category to the total of all facility costs. The proportion of allowable medical assistance costs to total facility costs establishes the percentage of the daily rate eligible for medical assistance payment.

Rate Formula:

The medical assistance payment is the computed medical assistance percentage of the daily rate multiplied by the total facility daily rate.

All of the following conditions must be met in order for a claim to be made:

(1) residents must be eligible for medical assistance
(2) residents received rehabilitative services that day
(3) all documentation requirements are met

4.b. Early and periodic screening, diagnosis, and treatment services: (continued)

A residential facility's daily medical assistance rate will be reviewed and updated quarterly for changes in the negotiated rate and annually for changes in time study or cost data.

- **Personal care IFSP/IEP services** provided by school districts during the school day to children with IFSPs/IEPs are paid pursuant to the methodology in item 13.d., Rehabilitative services.

Other EPSDT providers are paid in accordance with the methodology set forth elsewhere in this Attachment for the provider type enrolled to provide the service.

13.d. Rehabilitative services.

Rehabilitative services are paid using the same methodology in item 5.a., Physicians' services, except as listed below.

- **Physical therapy assistants** are paid using the same methodology as item 11.a., Physical therapy.

- **Occupational therapy assistants** are paid using the same methodology as item 11.b., Occupational therapy.

- Payment for mental health services is made in accordance with the methodology set forth elsewhere in this Attachment for the provider type enrolled to provide the service. Effective for mental health services provided on or after July 1, 2001, payment is the lower of the submitted charge or 75.6% of the 50th percentile of 1999 charges.

- **Basic living and social skills** provided as part of mental health community support services are paid:

  - for mental health professionals or mental health practitioners, the lower of the submitted charge or $18.00 per 30 minute unit;

  - for mental health rehabilitation workers, the lower of the submitted charge or $13.50 per 30 minute unit; or

  - in a group setting, regardless of the provider, the lower of the submitted charge or $11.00 per 30 minute unit. For the purposes of mental health community support services, "group" is defined as two to 10 recipients.

- **Consultation with significant people** provided as part of mental health community support services are paid:

  - for mental health professionals or mental health practitioners, the lower of the submitted charge or $9.00 per 15 minute unit; or

  - for mental health rehabilitation workers, the lower of the submitted charge or $6.75 per 15 minute unit.

13.d. Rehabilitative services. (continued)

- **Medication education** provided as part of mental health community support services are paid:
  - the lower of the submitted charge or $10.00 per 15 minute unit; or
  - in a group setting, the lower of the submitted charge or $6.50 per 15 minute unit.
- **Crisis assessment** provided as part of mental health crisis response services are paid:
  - for doctoral prepared mental health professionals, the lower of the submitted charge or $32.50 per 15 minute unit;
  - for master's prepared mental health professionals, the lower of the submitted charge or $26.00 per 15 minute unit;
  - for mental health practitioners supervised by doctoral prepared mental health professionals, the lower of the submitted charge or $16.25 per 15 minute unit; or
  - for mental health practitioners supervised by master's prepared mental health professionals, the lower of the submitted charge or $13.00 per 15 minute unit.
- **Crisis intervention** provided as part of mental health crisis response services are paid:
  - for doctoral prepared mental health professionals, the lower of the submitted charge or $47.50 per 30 minute unit;
  - for master's prepared mental health professionals, the lower of the submitted charge or $38.00 per 30 minute unit;

13.d. Rehabilitative services. (continued)

- for mental health practitioners supervised by doctoral prepared mental health professionals, the lower of the submitted charge or $23.75 per 30 minute unit; or

- for mental health practitioners supervised by master's prepared mental health professionals, the lower of the submitted charge or $19.00 per 30 minute unit.

- **Crisis stabilization** provided as part of mental health crisis response services are paid:

  - for mental health professionals or mental health practitioners, the lower of the submitted charge or $19.50 per 30 minute unit;

  - for mental health rehabilitation workers, the lower of the submitted charge or $14.62 per 30 minute unit;

  - in a group setting, regardless of the provider, the lower of the submitted charge or $11.00 per 30 minute unit. For the purposes of mental health crisis response services, "group" is defined as two to 10 recipients.

- **Consultation with significant people** provided as part of mental health crisis response services are paid:

  - for mental health professionals or mental health practitioners, the lower of the submitted charge or $9.00 per 15 minute unit; or

  - for mental health rehabilitation workers, the lower of the submitted charge or $6.75 per 15 minute unit.

- Effective January 1, 2002, provider travel time is covered if a recipient's individual treatment plan requires the provision of ~~day treatment~~ mental health services outside of the provider's normal place of business. This does not include travel time included in other billable services.

13.d. Rehabilitative services. (continued)

- Payment for EPSDT services identified in IFSPs/IEPs and provided by school districts to children with IFSPs/IEPs during the school day is pursuant to a cost-based, per child encounter rate.

- Payment for outpatient chemical abuse programs services is pursuant to county-negotiated rates.

INTERIM RATE METHODOLOGY FROM JULY 1, 2000 THROUGH JUNE 30, 2002

From July 1, 2000, through June 30, 2002, interim rates will be developed for each school district, for each provider type within that school district. The rates will be based upon a two-month survey of school-based providers of IFSP/IEP services and audited cost data (salary plus fringe benefits).

A child count will be collected from each IFSP/IEP provider. The child count includes the number of children served by each provider type participating in that school district.

Interim Rate Formula: Cost per school district, per provider type, divided by the child count for that provider type.

INTERIM RATE METHODOLOGY EFFECTIVE JULY 1, 2002

School districts are paid interim rates using cost-based, per child encounter rates using data collected during the previous year.

Interim Rate Formula: The interim rate formula is the same as the final rate formula effective July 1, 2000. The rate will be reviewed and updated annually, using the most current available data.

FINAL RATE METHODOLOGY EFFECTIVE JULY 1, 2000

At the end of the interim rate year, the Department will settle up with school districts using actual data reported for the payment year.

13.d. Rehabilitative services. (continued)

Final Rate Formula: The final rate is derived by dividing salaries plus fringe benefits by total employment hours. This result is multiplied by medical assistance direct service hours, then divided by medical assistance encounters.